Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q1 and Q2 of CY 2022

Illinois Department of Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

Introduction

Section 5-30.1 of Public Act 100-0580[1] amends the Public Aid Code to require Healthcare and Family Services (HFS) to "post an analysis of [Managed Care Organization, or] MCO claims processing and payment performance on its website every 6 months." The required analysis mandates a review and evaluation of hospital claims that are rejected and denied, the top 5 reasons for such actions, and timeliness of claims adjudication (focusing upon 30, 60, 90, and 90+ day timeframes). This report is being posted pursuant to Public Act 100-0580.

Date Span of Data

The data provided in this report covers Quarter1 (Q1, or the dates January 1, 2022 through March 31, 2022, and Quarter 2 (Q2), or the dates April 1, 2022 through June 30, 2022, of calendar year 2022.

Data Inclusions and Exclusions

The data analyzed in this report focuses solely on institutional hospital claims, or claims submitted via 837I, or its paper variant (UB04), by hospitals. This means that all other claim types, including professional claims submitted via 837P, or its paper variant (CMS-1500), by hospitals and all other providers, are not included in this report. Professional claims billed by hospitals were excluded as they are processed and often paid in a different manner than institutional claims which makes aggregating the claims potentially misleading. In addition to these professional claims, adjustments were held back from this reporting period. Adjustments can complicate processing periods and reimbursement methodologies and can be triggered for various technical reasons, as such it was determined that adjustments should be set aside until common ground in the data between plans could be established.

Representative Sample.

This report seeks to review all MCO inpatient hospitalization data in whole, establishing the entire data set as the representative sample.

Notes.

1. All dollar values provided in this report have been rounded to the nearest thousand-dollar value.
2. Regarding Charges Billed – Hospitals independently develop the values submitted on their claim as Charges Billed. Billed charges may be significantly higher than the allowable payments negotiated between payers and hospital.
3. Reimbursements detailed in this report do not include all payments made to hospitals under the Illinois Medicaid Program, as it excludes both fee-for-service payments made by HFS, and other payments made as a result of the hospital assessment program.

Data Collection Process

The data for this report was collected via Microsoft Excel in a standardized spreadsheet format established by the OMI. The spreadsheet format was disseminated by HFS on behalf of the OMI to all MCOs, and the data was submitted by the MCOs by the first week of March 2023.

All data in this report is provided via self-report from the MCOs. While the OMI seeks to provide data in the most accurate manner possible, data integrity errors may exist in this report related to discrepancies in the interpretation of instructions, variance in health plan data management, and the general potential for human error.

[1] See: http://www.ilga.gov/legislation/publicacts/100/100-0580.htm

Section 1. General Data

Unique Services and Denial Rate

To determine the rate at which hospital claims were being rejected or denied, the number of "unique services" was used instead of the raw volume of claims submitted to MCOs for payment. This was done because multiple claims can be submitted for one discrete service, or hospital stay. Counting unique services in effect removes duplicate claims. For example, if a provider were to submit a claim three times, each time receiving a denial for the same inpatient stay, that service under this methodology would be counted as a single denial. Additionally, given this same example, if a fourth claim submitted by the provider was paid, that service would be counted as a paid claim and not a denied claim, under this methodology – regardless of the three claims denials that occurred, leading to the service reimbursement. Tables 1A and 1B below show how many services were paid, denied, or rejected, and the associated dollar amounts for Quarters 1 and 2, respectively.

Table 1A. Unique Services. 2022 Q1

2022 Q1	Unique Service Count	% Of Services	Charges billed	Amount Paid
Unique Services Submitted	1,710,409	100.00%	$10,380,002,000	$1,310,515,000
Payable/Paid Unique Services	1,524,236	89.12%	$8,568,594,000	$1,310,515,000
Rejected Unique Services	61,260	3.58%	$521,478,000	[redacted]
Denied Unique Services	124,884	7.30%	$1,289,806,000	[redacted]
Total Non-Payable (Denied + Rejected)	186,144	10.88%	$1,811,284,000	[redacted]

Table 1B. Unique Services. 2022 Q2

2022 Q2	Unique Service Count	% Of Services	Charges billed	Amount Paid
Unique Services Submitted	1,747,018	100.00%	$10,431,972,000	$1,361,795,000
Payable/Paid Unique Services	1,582,767	90.60%	$8,852,274,000	$1,361,795,000
Rejected Unique Services	40,438	2.31%	$329,542,000	[redacted]
Denied Unique Services	123,796	7.09%	$1,249,911,000	[redacted]
Total Non-Payable (Denied + Rejected)	164,234	9.40%	$1,579,453,000	[redacted]

Approximately 10.9% of unique services submitted for Q1 and 9.4% of unique services for Q2 were either rejected or denied.

Submissions Before Positive Adjudication

Table 2 focuses on efficiency in the claiming process. Providers have the ability to submit unpayable claims multiple times in order to achieve an adjudication determination. Additionally, claims that are negatively adjudicated due to missing or wrong information can be updated and resubmitted for re-adjudication. This table groups positively adjudicated claims by the number of submissions needed for that positive adjudication.

Table 2A. Number of Submissions Before Positive Adjudication 2022 Quarter 1

2022 Q1	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,515,752	97.41%	$1,246,698,000
2nd Submission	37,323	2.40%	$89,845,000
3rd Submission	2,464	0.16%	$12,964,000
4th Submission	318	0.02%	$2,427,000
5th or More Submission	121	0.01%	$393,000
Total	1,555,978	100.00%	$1,352,327,000

Table 2B. Number of Submissions Before Positive Adjudication 2022 Quarter 2

2022 Q4	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,535,258	97.56%	$1,291,376,000
2nd Submission	36,189	2.30%	$81,096,000
3rd Submission	1,882	0.12%	$9,019,000
4th Submission	254	0.02%	$1,725,000
5th or More Submission	113	0.01%	$246,000
Total	1,573,696	100.00%	$1,383,462,000

In both Quarter 1 and Quarter 2, approximately 97.6% of claims were paid after one submission. This data is consistent with historical data prior to Quarters 3 and 4 of 2021, and therefore shows a return to the historical norms for claims paying performance. It also shows that that the current state of hospital claiming across the MCOs is efficient. Given the departure from historical performance shown in Q3 and Q4 of 2021, the data will be

monitored for future conformance with historical norms. Note: by efficient, it is meant that paid claims are usually paid upon first submission; no conclusions can be drawn about rejections or denials from these tables.

Timeframe of Claim Adjudication

Table 3 highlights the length of time it takes for claims, following submission, to be adjudicated by the MCOs.

Table 3A. Days for Claims to be Adjudicated
2022 Quarter 1

2022 Q1	Claims	% Of Claims	# Of Payable/ Paid Claims	Net Liability	# Of Non-Payable *	Charges Billed for Non-Payable*
Total Claims Adjudicated in 0-30 days	1,643,600	95.74%	1,501,573	$1,158,021,000	142,027	$1,428,310,000
Total Claims Adjudicated in 31-60 days	21,759	1.27%	16,315	$68,289,000	5,444	$116,527,000
Total Claims Adjudicated in 61-90 days	10,650	0.62%	7,228	$29,618,000	3,422	$56,386,000
Total Claims Adjudicated in 91+ days	40,678	2.37%	32,407	$101,273,000	8,271	$188,151,000
Total Claims Awaiting Adjudication	1,707					
Total Claims Adjudicated for DOS for Reporting Period	1,716,687	100.00%	1,557,523	$1,357,202,000	159,164	$1,789,374,000

* Non-Payable means rejected or denied.

Table 3B. Days for Claims to be Adjudicated 2022 Quarter 2						
2022 Q2	**Claims**	**% of Claims**	**# of Payable/ Paid Claims**	**Net Liability**	**# of Non-Payable ***	**Charges Billed for Non-Payable***
Total Claims Adjudicated in 0-30 days	1,698,072	96.95%	1,533,843	$1,241,653,000	164,229	$1,375,347,000
Total Claims Adjudicated in 31-60 days	18,037	1.03%	13,099	$70,077,000	4,938	$123,961,000
Total Claims Adjudicated in 61-90 days	9,737	0.56%	7,415	$14,241,000	2,322	$51,727,000
Total Claims Adjudicated in 91+ days	25,616	1.46%	19,632	$58,182,000	5,984	$115,016,000
Total Claims Awaiting Adjudication	15,003					
Total Claims Adjudicated for DOS for Reporting Period	1,751,462	100.00%	1,573,989	$1,384,153,000	177,473	$1,666,052,000
* Non-Payable means rejected or denied.						

The data in Table 3A shows that in Q1 95.7% of claims were adjudicated within 30 days, and Table 3B data shows that in Q2 approximately 97.0% of claims were adjudicated within 30 days. These numbers are consistent with historical experience for MCO. In Q3 of 2021 there was a significant departure from historical experience, which led to a large increase in the percentage of claims adjudicated in later durations. This was due to unique circumstances experienced by one MCO. Experience in Q4 2021 and in the current 2 Quarters (Q1-Q2 2022) shows that current experience has returned to historical levels. Future data submitted by this and all MCOs will be monitored for future variations from historical experience, as would normally be done.

Note. *Table 3 transitions away from reviewing unique services, as detailed in Table 1 and focuses on total claim volume, as such totals between Table 1 and Table 3 will not match. Additionally, given the nature of "usual and customary charges," the non-payable value should not be viewed as an exact or estimated amount owed or lost.*

Adjudication to Payment

Table 4 focuses on the release of money from the MCOs to the provider, following the adjudication of the hospital claim.

Table 4A. Time from Adjudication to Payment
2022 Quarter 1

2022 Q1	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Timeframe of Payment to Provider Following Positive Adjudication (0-30 days)	1,539,785	98.87%	$1,344,596,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	15,896	1.02%	$9,253,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	46	0.00%	$273,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	1,727	0.11%	$3,000,000
Total Payments Pending to Provider Following Positive Adjudication	31	[redacted]	$80,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,557,454	100.00%	$1,357,122,000

Data for Quarter 4 is shown on the following page.

Table 4B. Time from Adjudication to Payment 2022 Quarter 2			
2022 Q2	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Positive Adjudication (0-30 days)	1,562,934	99.31%	$1,369,201,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	9,341	0.59%	$6,049,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	302	0.02%	$1,378,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	1,228	0.08%	$658,000
Total Payments Pending to Provider Following Positive Adjudication	170		$6,868,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,573,805	100.00%	$1,377,286,000

Tables 4A and 4B show that approximately 99% of payments to hospitals from the MCOs were made within 30 days of claims adjudication in both Q1 and Q2 of 2022. These percentages are the same as the those reported for Q3 and Q4 of 2021, and continue to be among the highest percentages ever in Tables 4A and 4B by a substantial margin. Inspection of the data for Q1-Q2 2021 shows that for both Quarters, 4 of the 5 MCOs reported over 99.9% of claims paid within 30 days of positive adjudication.

Submission to Payment

Table 5: Interval -release of money from the MCOs to the provider, following submission of the hospital claim.

Table 5A. Time from Submission to Payment 2022 Quarter 1			
2022 Q1	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Submission of Claim (0-30 days)	1,467,777	94.24%	$1,073,148,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	47,859	3.07%	$148,332,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	7,490	0.48%	$30,362,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	34,360	2.21%	$105,280,000
Total Payments Pending to Provider Following Positive Adjudication	31	NA	$80,000
Total (Not including Pending)	1,557,486	100.00%	$1,357,122,000

Data for Q2 is shown on the next page.

Table 5B. Time from Submission to Payment 2022 Quarter 2			
2022 Q2	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Submission of Claim (0-30 days)	1,501,067	95.38%	$1,157,603,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	43,456	2.76%	$142,463,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	8,159	0.52%	$17,751,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	21,132	1.34%	$59,467,000
Total Payments Pending to Provider Following Positive Adjudication	170		$6,868,000
Total (Not including Pending)	1,573,814	100.00%	$1,377,284,000

The data for Table 5 show that the percentage of claims paid within 30 days of submission was 94.2% for Quarter 1 and 95.4% for Quarter 24. These percentages are significantly higher than those for Q3 and Q4 of 2021, and are also much higher than historical experience. The low percentages for Q3 and Q4 of 2021 were the result of the circumstances experienced by one MCO. Those issues have been addressed and resolved, and the results for Q1 and Q2 of 2022 reflect a rebound for this MCO from the claims paying performance for the last half of CY2021. Experience in future Quarters will continue to be monitored for future anomalies in the data.

Section 2. Rejections and Denials

Rejected Claims

A rejected claim is one in which the determination of payment cannot be made. These claims may enter the MCOs clearinghouse (front-end) but do not get passed on to the health plan's billing system for payment processing and adjudication (back-end) due to missing administrative elements on the claim. In most cases, the provider may address the issue causing the rejection and re-submit the claim for processing. Table 6 describes only the top ten codes, thus the percentages shown do not equal 100%.

Claim Adjustment Reason Code (CARC) Rejections

To gain common understanding across MCOs, hospital rejections by CARCs were collected and measured. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 CARC code rejection reasons are provided in Table 6.

Table 6A. Top 10 CARC Rejections 2022 Quarter 1

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
96	Non-covered charge(s).	8,997	23.11%
18	Exact duplicate claim/service	6,686	17.17%
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	5,678	14.58%
208	National Provider Identifier - Not matched.	4,341	11.15%
16	Claim/service lacks information or has submission/billing error(s).	3,109	7.98%
31	Patient cannot be identified as our insured.	2,811	7.22%
N/A	(None/Invalid code reported by MCO)	1,729	4.44%
27	Expenses incurred after coverage terminated.	1,495	3.84%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	1,291	3.32%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	555	1.43%
	Total Rejections (Duplicative)	38,937	

Table 6B. Top 10 CARC Rejections 2022 Quarter 2			
CARC Code	**CARC Code Description**	**Total Claims**	**Percent of Claims Rejected**
96	Non-covered charge(s).	7,821	25.65%
18	Exact duplicate claim/service	7,085	23.23%
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	5,512	18.08%
31	Patient cannot be identified as our insured.	2,308	7.57%
16	Claim/service lacks information or has submission/billing error(s).	2,262	7.42%
27	Expenses incurred after coverage terminated.	1,445	4.74%
N/A	(None/Invalid code reported by MCO)	1,169	3.83%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	754	2.47%
208	National Provider Identifier - Not matched.	576	1.89%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	352	1.15%
	Total Rejections (Duplicative)	**30,494**	

Note. *While CARC and RARC codes are standardized, the manner in which a payer chooses to map CARCs and RARCs to their internal Explanation of Benefits (EOB), or proprietary coding can be nuanced, resulting in a difference in application or usage between plans.*

Remittance Advice Remark Code (RARC) Rejections

To gain common understanding across MCOs, hospital rejections by RARCs were collected and measured for the first time. Though each of the plans may map and utilize RARCs in a slightly different manner, the top 10 RARC code rejection reasons are provided in Table 7. RARCs provide additional information regarding claim action and may or may not be present on all claims. Table 7 describes only the top ten codes, thus the percentages shown do not equal 100%.

Table 7A. Top 10 RARC Rejections 2022 Quarter 1

RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
M86	Service denied because payment already made for same/similar procedure within set time frame.	9,119	28.77%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	8,331	26.28%
N30	Patient ineligible for this service.	3,712	11.71%
N253	Missing/incomplete/invalid attending provider primary identifier.	3,578	11.29%
M56	Missing/incomplete/invalid payer identifier.	2,759	8.70%
N/A	(None/Invalid code reported by MCO)	1,409	4.44%
N286	Missing/incomplete/invalid referring provider primary identifier.	722	2.28%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	492	1.55%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	345	1.09%
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	275	0.87%
	Total Rejections (Duplicative)	31,700	

Table 7B. Top 10 RARC Rejections 2022 Quarter 2			
RARC Code	**Code Description**	**Total Rejections**	**Percent of Claims Rejected**
M86	Service denied because payment already made for same/similar procedure within set time frame.	8,252	34.81%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	7,054	29.75%
N30	Patient ineligible for this service.	3,710	15.65%
M56	Missing/incomplete/invalid payer identifier.	2,017	8.51%
N/A	(None/Invalid code reported by MCO)	899	3.79%
N253	Missing/incomplete/invalid attending provider primary identifier.	500	2.11%
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	254	1.07%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	224	0.94%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	111	0.47%
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	97	0.41%
	Total Rejections (Duplicative)	23,707	

While the rejection reasons are varied, the data in the table demonstrates that most rejections are related to technical claiming issues (e.g., missing information, incomplete data, taxonomy issues, plan guideline issues, claim format, payee data, etc.).

Denied Claims

A denied claim is a claim submitted by a provider that is not rejected by the clearinghouse but is adversely adjudicated by an MCO based upon one of seven defined HFS denial reason codes. These claims are HIPAA compliant and are fully processed by the MCO claims system but may be denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue, or other non-contracted provider related issue.

Top Denial Reasons

Denial reasons were reported using CARCs and RARCs, as well as the seven HFS-approved denial codes. The seven denial code categories were created for MCOs to use when submitting encounter data to HFS. Table 8 focuses on denials grouped by denial reason code.

Table 8A. HFS Denial Reasons
2022 Quarter 1

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	6,698	6.14%
Additional Information	49,426	45.27%
Authorization	11,787	10.80%
Benefit / Covered Service	35,888	32.87%
Medical Necessity	638	0.58%
Pre-Certification	3,767	3.45%
Provider	968	0.89%
Total Denials	109,172	100.00%

Note: Data for Quarter 2 is shown on the next page.

Table 8B. HFS Denial Reasons 2022 Quarter 2		
Denial Reason	**# Claims Denied**	**Percent of Claims Denied**
Timely Filing	5,418	4.23%
Additional Information	70,037	54.73%
Authorization	11,137	8.70%
Benefit / Covered Service	35,904	28.06%
Medical Necessity	626	0.49%
Pre-Certification	3,696	2.89%
Provider	1,151	0.90%
Total Denials	127,969	100.00%

Across quarters Q1 and Q2, “Additional Information” is the primary denial reason code followed by issues related to “Benefit/Covered Service”, “Authorization”, and “Timely Filing”. “Medical Necessity” of services continues to be a non-factor with respect to denials, for services that do not require prior authorization or additional information.

Claim Adjustment Reason Code (CARC) Denials

In an effort to gain common understanding across MCOs, hospital denials by CARCs were collected and measured for the first time. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 CARC code denial reasons are provided in Table 9. As only the top 10 reasons are shown, the percentages do not equal 100%.

Table 9A. Top 10 CARC Denials 2022 Quarter 1

CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
96	Non-covered charge(s).	24,640	17.81%
129	Prior processing information appears incorrect.	16,293	11.78%
197	Precertification/authorization/notification/pre-treatment absent.	12,958	9.36%
16	Claim/service lacks information or has submission/billing error(s).	10,610	7.67%
A1	Claim/Service denied.	9,759	7.05%
N/A	(None/Invalid code reported by MCO)	8,921	6.45%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	8,184	5.91%
22	This care may be covered by another payer per coordination of benefits.	7,932	5.73%
18	Exact duplicate claim/service	6,647	4.80%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5,386	3.89%
	Total Denials (Duplicative)	138,368	

Table 9B. Top 10 CARC Denials 2021 Quarter 2			
CARC Code	**CARC Code Description**	**Total Claims denied**	**Percent of Claims Denied**
96	Non-covered charge(s).	42,155	28.48%
129	Prior processing information appears incorrect.	14,059	9.50%
197	Precertification/authorization/notification/pre-treatment absent.	11,851	8.01%
N/A	(None/Invalid code reported by MCO)	11,689	7.90%
A1	Claim/Service denied.	10,094	6.82%
16	Claim/service lacks information or has submission/billing error(s).	8,908	6.02%
22	This care may be covered by another payer per coordination of benefits.	7,890	5.33%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	7,403	5.00%
18	Exact duplicate claim/service	5,641	3.81%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5,143	3.47%
	Total Denials (Duplicative	148,026	

Overall, the CARC denial detail in Tables 9A and 9B compliment and expand on the information found in Tables 8A and 8B. While the primary denial reason is related to non-covered charges, most other codes detail procedural issues (precertification, benefit covered in another service, time limit for filing has expired, charge exceeds fee schedule, service not covered, etc.) that providers are struggling to meet in accordance with plan requirements.

Remittance Advice Remark Code (RARC) Denials

In an effort to gain common understanding across MCOs, hospital denials by RARCs were collected and measured for the first time. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 RARC code denial reasons are provided in Table 10. As only the top 10 reasons are shown, the percentages do not equal 100%.

Table 10A. Top 10 RARC Denials 2022 Quarter 1

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	20,075	18.27%
N/A	(None/Invalid code reported by MCO)	17,365	15.81%
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	14,077	12.81%
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	4,983	4.54%
M62	Missing/incomplete/invalid treatment authorization code.	4,628	4.21%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	4,067	3.70%
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	3,435	3.13%
N253	Missing/incomplete/invalid attending provider primary identifier.	3,203	2.92%
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	3,198	2.91%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	2,228	2.03%
	Total Denials (Duplicative)	109,864	

Table 10B. Top 10 RARC Denials 2022 Quarter 2			
RARC Code	**Description**	**Total Claims Denied**	**Percent of Claims Denied**
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	38,585	31.16%
N/A	(None/Invalid code reported by MCO)	17,476	14.11%
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	11,941	9.64%
N253	Missing/incomplete/invalid attending provider primary identifier.	5,884	4.75%
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	5,024	4.06%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	3,944	3.18%
M62	Missing/incomplete/invalid treatment authorization code.	3,460	2.79%
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	3,332	2.69%
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	3,019	2.44%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	2,272	1.83%
	Total Denials (Duplicative)	123,834	

The data in Table 10A and 10B demonstrate that the HFS-contracted MCOs continue to rely significantly upon proprietary remittance advice coding or single-level CARC coding in their messaging to providers on denials, with 15.81% of denials in Q1 and 14.11% of denials in Q2 being attributed to the “None / Invalid Code” used by MCOs.

Conclusion

There was an 89.1% clearance rate of hospital claims reported against $1,311M in payable claims in Q1. The clearance rate in Q2 increased to 90.6% against $1,362M in payables. Additionally, approximately 97.4% of hospital services claims in Q1 and 97.6% in Q2 are being adjudicated by HFS' MCOs upon first submission (another strong metric of efficiency).

From a financial perspective, hospital claiming from MCOs can be qualified as ***generally paying hospitals within 60 days of claims submission***. This characterization is supported by approximately 97% of claims in Q1 and 98% of claims in Q2 being adjudicated within 60 days of submission from a provider. This was followed by approximately 99% of adjudicated claims in Q1 being paid to providers within 30 days of adjudication, and in 99% of adjudicated claims being paid within 30 days of adjudication in Q2. In totality, for Q1 and Q2 2022, virtually all payable claims are adjudicated and paid to providers within 60 days of submission (99.9% in both Q1 and Q2 2022). As discussed previously, in Q3 2021 there was a substantial departure from the historical rate of claims being paid within 30 days of adjudication. This was the result of significant anomaly in the data one of the larger MCOs. This anomaly has been addressed, and the aggregate data for all MCOs for Q1 and Q2 is similar to or exceeds the historical data. As future data is reported, this percentage (of claims paid) will be followed, to look for possible data anomalies. Finally, it is be noted that by the 30 day standard, pursuant to 305 ILCS 5/5-30.1. Managed Care Protections, sub-section (g), about 1.0% of claims in Q1 and 0.7% of claims in Q2 would be eligible for interest from MCOs, as they were not adjudicated and paid to the provider within 30 days of submission.

As with previous reports, CARCs and RARCs continue to be collected. However, each plan's use of CARCs and RARCs has its own nuances. While the inclusion of CARCs and RARCs provide additional detail, a crosswalk between plans would provide a better understand each plan's payment processes.

Office of Medicaid Innovation

This report was prepared by the Office of Medicaid Innovation (OMI) at the request of Department of Healthcare and Family Services (HFS).

The OMI is a specialty unit within the University of Illinois System that seeks to utilize U of I resources from across all its campuses to provide administrative, clinical, and operational support to HFS in the administration of the Illinois Medical Assistance Program.

The OMI can be contacted at:

University of Illinois
Office of Medicaid Innovation
3135 Old Jacksonville Road
Springfield, Illinois 62704-6488

Definitions:

Adjudicated Claim: A claim that has been processed by the MCO or its vendor, and a determination as to whether or not that claim is payable has been made. Claims that have been Rejected or Denied, or have been determined Payable, or that have been paid, are all adjudicated Claims.

Claim Adjustment Reason Code (CARC): A HIPAA mandated code set to be used in an Electronic Remittance Advice explaining why an action was taken on a claim.

Date of Submission: This is the date that a claim, paper or electronic, is received by either the MCO or their agent (i.e., EDI clearinghouse).

Denied/Denied Claim: A claim where the payment was denied by the MCO to a Provider corresponding to HFS defined administrative reasons/codes. These claims are HIPAA compliant and may be fully processed by the MCO claims system but are denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue and non-contracted Providers. For purposes of this report, MCOs are to report the relative counts into one of the following seven (7) Denial Reasons.

> **Note**: HFS defines denials as denial of payment for a claim for the seven Denial Reasons described in this section of the report, and only these reasons.
> Additional Information: Provider claim is denied because the Provider has failed to supply the required information and the MCO needs the Provider to submit more information to process the claim (i.e., doctor's notes).
>
> *Authorization*: Provider claim is Denied by MCO because Provider did not meet MCO's authorization policy on Provider network status, service limits, medical necessity, non-emergency services, or missing/invalid authorization form/record.
>
> *Benefit/ Covered Service*: Provider claim is denied by MCO because Provider did not meet MCO's policy for Covered Services which are eligible for reimbursement. Note that the MCO may cover some services which are traditionally not covered by HFS as stated under Section 104 of Chapter 100 – Handbook for Providers of Medical Services (https://www.illinois.gov/hfs/SiteCollectionDocuments/100.pdf). If there is TPL benefit for which the MCO Denied coverage, it should be reported as a Benefit/Covered Service denial.
>
> *Medical Necessity*: Provider claim is denied by MCO because Provider did not meet MCO's reimbursement policy for medical necessity.
>
> *Pre-certification*: Provider claim is denied by MCO because Provider did not meet MCO's pre-certification for Hospital and SUPR (formerly DASA) services.
>
> *Provider*: Provider claim is denied by MCO because: 1) Provider is sanctioned by OIG, 2) Provider is not registered with HFS, including Providers who are out-of-state and not registered with HFS, and 3) Provider isn't certified or eligible to be paid for this procedure/service on this date of service. It is expected that Provider works with HFS IMPACT/OIG team to activate their status so

that claims can be reprocessed by MCOs for reimbursement. (In each of these cases, MCOs have decided to reimburse $0 and nothing will change that reimbursement value, until the Provider is enrolled with HFS.)

Timely Filing: Provider claim is denied by MCO because Provider did not meet MCO's timely filing policy, including any waiver period.

Hospital Claims: All claims, billed by a provider who is enrolled with HFS' Medical Programs as a General Hospital (Provider Type 030), Psychiatric Hospital (PT 031), or Rehabilitation Hospital (PT 032). NOTE: Only report Institutional hospital claims are included in this report.

Paid Claim: A claim submitted by a provider to a MCO that has been adjudicated, resulting in reimbursement to the provider.

Payable Claim: A claim submitted by a provider to a MCO that has been adjudicated and determined to be payable.

Rejected/ Rejected Claim: A rejected billing claim is one in which the determination of payment cannot be made. These claims may enter payer claims system (front-end) but do not pass further into adjudication and payment processing (back-end) due to missing administrative elements on the claim. All claims categorized as denied/rejected due to ineligibility, or claims denied/rejected because a duplicate claim has already been paid, as a rejected claim.

Rejected claims are:

1) Claims submitted to an MCO that were accepted through the Electronic Data Interchange (EDI), but subsequently removed/deleted from the adjudication system;

2) Claims that rejected through the EDI translator for failing any SNIP (see definition below) validations; and

3) Any custom business rules implemented in EDI that reject claim submissions.

Examples of missing administrative elements include taxonomy code, value codes, occurrence codes, modifier codes, billed units, covered days, invalid recipient ID, notes, and NDC codes. In most cases, once the administrative element is added and the claim is resubmitted by the Provider to the MCO, the claim may be adjudicated.

Remittance Advice Remark Code (RARC): A HIPAA mandated code set to be used in an Electronic Remittance Advice explaining why an action was taken on a claim. It is used in addition to a CARC. Not all actions require a RARC.

Unique Service: Multiple claims can be submitted for one service. To report Unique Services only report unique combinations of a provider's NPI/ Medicaid ID, patient Recipient ID/ Medicaid ID, admission through discharge date, and bill type. NOTE: For institutional claims, report Unique Services at the claim level of detail.